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A Historical-Institutionalist Analysis of the MV *Sewol* and MS *Estonia* Tragedies: Policy Lessons from Sweden for South Korea*

Jörg Michael Dostal**, Hyun-jin Kim***, and Albin Ringstad****

Abstract: On April 16, 2014, the South Korean ship MV *Sewol* sank, claiming the lives of 304 passengers. The accident appeared to observers to be a man-made disaster, since all the passengers could have been rescued if adequate safety measures and disaster management procedures had been in place. The *Sewol* sinking has subsequently turned into a focusing event in terms of safety policy debates in South Korea. On September 28, 1994, the Swedish ship MS *Estonia* sank, claiming the lives of 852 people. This earlier tragedy was also a focusing event in the context of Swedish debates about safety policies. In this article, South Korean and Swedish safety policies are analyzed from a historical-institutionalist perspective. While Swedish disaster prevention systems have generally performed well in a virtuous cycle, those of South Korea have performed poorly in a vicious cycle. The article highlights how South Korean policy makers might use Swedish policies, developed in response to the 1994 MS *Estonia* accident, to improve their safety policies. In addition, we suggest that long-term policies focusing on comprehensive social welfare and the pooling of risks are required to restore citizens' trust in government and to transform South Korea from a low safety into a high safety society.

Keywords: historical institutionalism, Korea, MS *Estonia*, MV *Sewol*, safety policy, Sweden

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INTRODUCTION

On April 16 2014, the South Korean ship *MV Sewol* sank near the southwestern island of Jin-do. The tragedy claimed the lives of 304 people and immediately triggered a nation-wide outpouring of grief due to the fact that pupils on a school trip made up a significant proportion of the victims. The public quickly took note of the fact that the *Sewol* disaster was man-made: if adequate safety measures and disaster management procedures had been in place, it could have easily been prevented.

The media coverage subsequently focused on issues such as failure in disaster management on the part of the South Korean government and the unethical business practices of the people related to Chunghaejin Shipping, the holding company of the *MV Sewol*. Families of the victims waited for months at Pang-Mok harbor in hope of retrieving deceased bodies from the sea. Sentiment that the incompetency of the South Korean government had been a major cause of the disaster was widespread. After the disaster, 67 memorial sites were installed by citizens throughout the country, which were visited by approximately 2,204,224 citizens during the first 100 days after the sinking of the *MV Sewol* (*Yonhapnews*, 2014). Moreover, citizens expressed their sympathy by wearing yellow ribbons. They also demanded the government legislate new safety laws and conduct a thorough investigation of the circumstances of the accident in order to punish those who had directly contributed to the chain of events that triggered it.

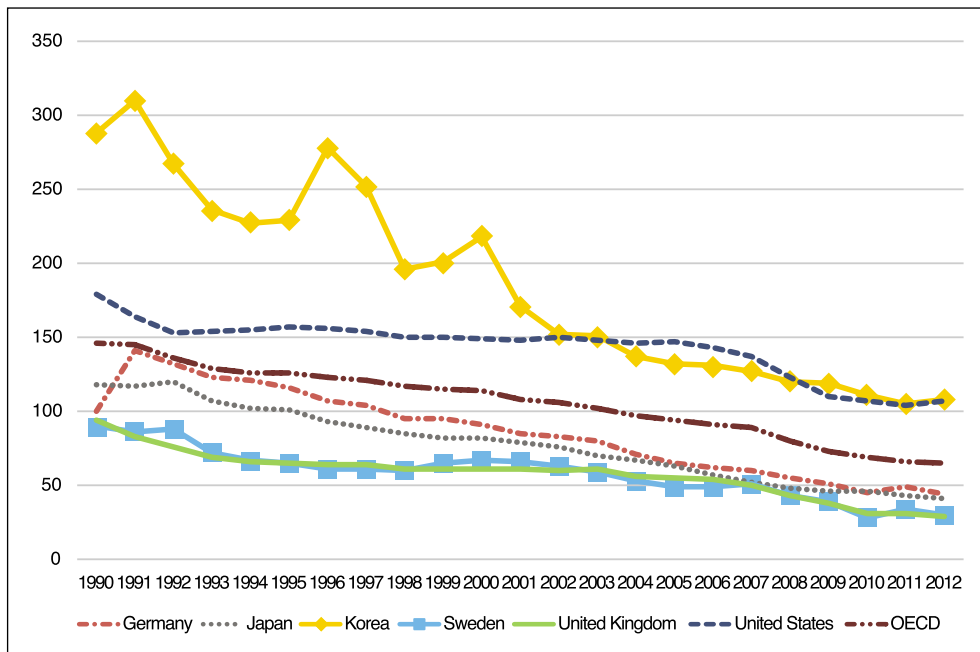
In summary, the *MV Sewol* sinking has clearly been a *focusing event* for policy making in South Korea in line with the definition advanced by Birkland (1998, p. 54), namely one that is “sudden; relatively uncommon; can be reasonably defined as harmful or revealing the possibility of potentially greater future harms; has harms that are concentrated in a particular geographical area or community of interest; and [...] is known to policy makers and the public simultaneously.” Typically, a focusing event is followed by a series of new policy developments in the relevant field. Thus, the South Korean government might adopt or develop new safety-related policies in reaction to the *Sewol* disaster. In this article, the Swedish case of the 1994 *MS Estonia* disaster, which claimed the lives of 852 people, and the South Korean case of the 2014 *MV Sewol* disaster are examined from a comparative point of view. We argue that the *MS Estonia* disaster triggered improvements in safety policies in Sweden in line with a “virtuous cycle” of policy making theorized in this article. We claim that South Korea could learn important lessons from Sweden that could help it escape the existing “vicious cycle” in the country’s policy making with regard to safety issues.

We put forward a two-tiered argument in this article. First, we present relevant data on safety levels in Sweden and South Korea (as well as some other OECD countries

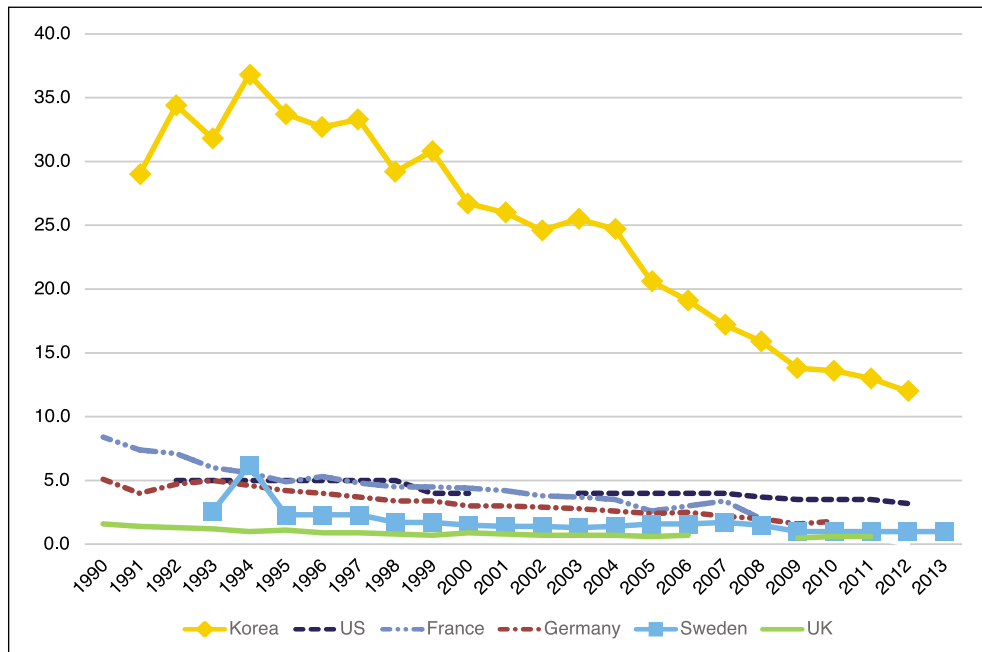
for illustrative purposes) and analyze the underlying structural reasons for the relative success and failure of safety policies in both countries. Second, we put forward a comparative case study of the *MV Sewol* and *MS Estonia* tragedies to test the theoretical framework. We conclude by highlighting relevant Swedish policy lessons that South Korean policy makers might adopt to improve safety levels in South Korea in the future.

Figure 1 shows the level of road safety in OECD countries. Although South Korean safety levels have improved over the past 20 years, there is a marked difference between it and Sweden in this respect. Figure 2 shows the death rate due to industrial accidents per 100,000 people in South Korea and Sweden. The industrial accident risk in South Korea is higher than it is in Sweden. While there have been at least 20 man-made major tragedies in South Korea since the 1950s, there were only six major disasters overall—not all of them man-made—in Sweden during the same period (“major” being defined in this article as an accident that results in more than 10 casualties). Such differences in safety levels are due to different sets of safety management institutions in both countries, resulting in the emergence of a vicious cycle and a virtuous cycle, respectively.

Figure 1. Road Accident Fatalities per Million Inhabitants



Source: OECD iLibrary.

Figure 2. Deaths from Industrial Accidents per 100,000

Source: ILO.

Note: ILO data derives from reports on occupational safety as submitted by national labor-related offices. Available Japanese data on industrial accidents is not comparable and is omitted here. Available data from South Korea, France, and Germany derives from reports on numbers of legally compensated industrial deaths in line with the ILO's latest definition. Data on Sweden, US, and UK derives from reported deaths at work (the ILO's former definition of death from industrial accidents). In addition, data on South Korea and France covers only those workers who are registered for workmen's accident compensation insurance (i.e. only "regular" workers are covered in the case of South Korea). In turn, Swedish, US, and UK data represent all registered employees. Data on South Korea (2013), the US (2001, 2002), Germany (2011, 2012, 2013), UK (2007, 2008, 2012, 2013), and Sweden (1990, 1991, 1992) is currently missing.

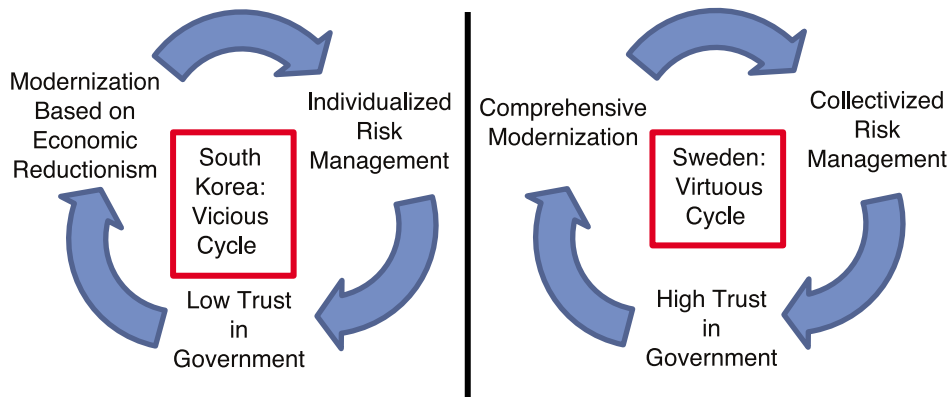
In summary, Swedish disaster prevention systems have performed far better and did so even before the focusing event of the *MS Estonia* tragedy than South Korean disaster prevention systems. Even as the early industrialization period in South Korea comes to a close, South Korea remains one of the least safe OECD societies. We thus examine historical path dependencies, institutions, and actors in the safety field and scrutinize how they interact with larger society in a comparative manner in order to derive relevant policy lessons.

HISTORICAL INSTITUTIONALISM

Historical institutionalism, the approach we use in this study, offers certain advantages when conducting a small-N comparative case study. First, it examines institutions. “The most common definition for institutions is: rules” (Steinmo, 2008, p. 123). The logic of “institutions are rules” allows a consideration of all possible factors structuring the behavior of socialized actors, including informal normalities, formal laws, formal organizations, and informal networks (Steinmo, 2008). In other words, an analysis that takes a historical institutionalist approach examines a large number of variables to test a hypothesis. However, historical institutionalism does not define human beings as mere rule-abiding automatons. Rather, historical institutionalism takes the strategic behavior of actors who are surrounded by institutions into account. “Actors’ interpretations of their interests [are] shaped by collective organizations and institutions that bear traces of own history” (Immergut, 1998, p. 18). Furthermore, historical institutionalism helps to explain contextual procedures and real world outcomes in existing institutions (Steinmo, 2008). Since interests motivating certain actions of socialized actors are contextually constructed, the resulting root causes of behavioral patterns over relatively long time can be detected and analyzed by adopting a historical institutionalist approach.

Most political science research in historical institutionalism highlights *path dependency* and *critical juncture* in an effort to establish causality in actors’ behavior. As Capoccia and Kelemen (2007, p. 341) state, “Many causal arguments in the historical institutionalist literature postulate a dual model of institutional development characterized

Figure 3. Vicious Cycle and Virtuous in South Korea and Sweden



Note: The two cycles are based on Beck 1986, D. Y. Kim 2014, G. A. Shin 2013, Hort (2014a, 2014b), Rothstein & Uslaner 2005, and Kumlin & Rothstein 2005.

Table 1. Features of Modernization, Risk Management, and Trust in Government in South Korea and Sweden

Economic/ Political Features	South Korea	Sweden
modernization based on economic reductionism versus comprehensive modernization	1) economic discourse as main feature of politics from 1960s to 2010s 2) unequal wealth distribution, high social inequality 3) role of labor unions before and after democratization was marginal	1) political dynamism based on multiparty system and developed civil society 2) egalitarian tradition already in place before the development of the modern welfare state 3) unions were major policy actors throughout the twentieth century
individualized risk management versus collectivized risk management	1) nonexistence of basic social welfare institutions (e.g., education and health care are mostly private) 2) market-driven globalization and “marketized individualization” 3) Emphasis on competitive individualism	1) comprehensive welfare and additional voluntary organizations (e.g., Church of Sweden) 2) developed welfare system moderates negative effects of globalization 3) Emphasis on the self as part of a larger community
low trust in government versus high trust in government	1) “what has government done for me?” mentality 2) very low trust in government in comparison to other OECD countries	1) willingness to pay high taxes 2) high trust in government by OECD standards, which has been stable over long periods of time

by relatively long periods of path-dependent institutional stability and reproduction that are punctuated occasionally by brief phases of institutional flux—referred to as critical junctures—during which more dramatic change is possible.”

Figure 3 shows the path-dependent logic of institutions in South Korea’s vicious cycle and in Sweden’s virtuous cycle. The elements of each cycle are causes and effects at the same time. Table 1 explains the historical background of the two contrasting cycles.

Vicious Cycle in South Korea

The economic development of South Korea from the 1960s onward was guided by the state. With regard to state activities, Kim Duk-yung (2014, p. 65) contends that there was and still is a tendency “to reduce modernization to matters of the economy.” Because modernization focused on the economy, other institutions such as political, social, and cultural ones are relatively underdeveloped. Their development was only promoted as long as they served the economic sector. As a result, South Korean society

did not achieve comprehensive modernization (D. Y. Kim, 2014).

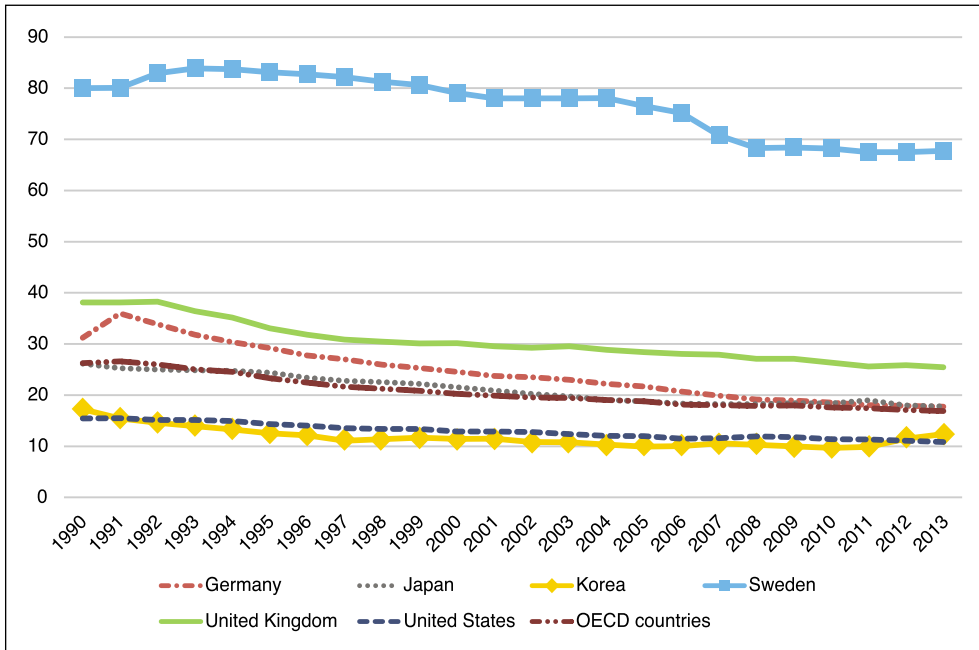
The reduction of modernization to economic development came during the Park Chung-hee regime (1961-1979) with the introduction of the five-year national plans. The Chun Doo-hwan regime (1980-1988) and the Roh Tae-woo administration (1988-1993) continued along the path established by the Park regime. The democratization movements of the working- and new middle classes in the 1980s ultimately failed to overturn the reductionist model.

During the Kim Young-sam administration (1993-1998), South Korea's economy suffered a blow as a result of the Asian financial crisis of 1997 and 1998. In reaction to the crisis, the IMF required that formerly state-guided sectors and the labor market be deregulated in order for South Korea to qualify for financial loans. The Kim Dae-jung administration (1998-2003), the first liberal government in the history of South Korea, was also affected by the financial crisis and was unable to transform the existing institutional setting. The Roh Moo-hyun administration (2003-2008), the second liberal government, introduced the agenda of "the era of \$20,000 GDP per capita" at the initial phase of its term, and institutions were expected to support this agenda.

Throughout Kim's and Roh's terms, the organized pattern of economic reductionism became even more entrenched and efforts to introduce new modes of policy making such as institutionalized social dialogue between employers and unions failed. The election pledge of the conservative Lee Myung-bak administration (2008-2013) was "7-4-7." This indicated a scheme to aim for "7 percent of GDP growth to achieve \$40,000 GDP per capita within 7 years," which turned out to be vastly unrealistic. The current conservative Park Geun-hye administration (2013-2018) announced plans to lead a "second Han River miracle" with the concept of a "creative economy." However, the government has so far mostly focused on new deregulatory policies, and the president has described regulations in this context as "a lump of cancer" (Park, 2014).

In summary, there exists a clear path dependency in South Korean state governance that is grounded in economic reductionism, which is replicated and reinforced in other institutional settings of South Korean society. For example, education is primarily a tool for becoming more successful in the labor market, and families are expected to assist economic development as providers of welfare services covering societal risks such as unemployment, poverty, elderly care, and child care.

The Park Chung-hee regime implemented the idea of basing the national economy on *chaebols*, that is, family-owned and export-oriented industrial conglomerates producing goods and services in many different economic sectors. This policy forced non-*chaebol* companies to serve the needs of the larger corporations. Crucially, *chaebol* companies adopted a "company is family" ideology (D. Y. Kim, 2014, p. 186) to make employees obedient. Whenever workers organized themselves in independent unions,

Figure 4. Trade Union Density

Source: OECD iLibrary and KOSIS Economically Active Population Survey 2015 for Korean data of 2012 and 2013.

the state suppressed these activities. At present, union membership in South Korea amounts to only 9.9 percent while that of Sweden is 67.7 percent as shown in figure 4.

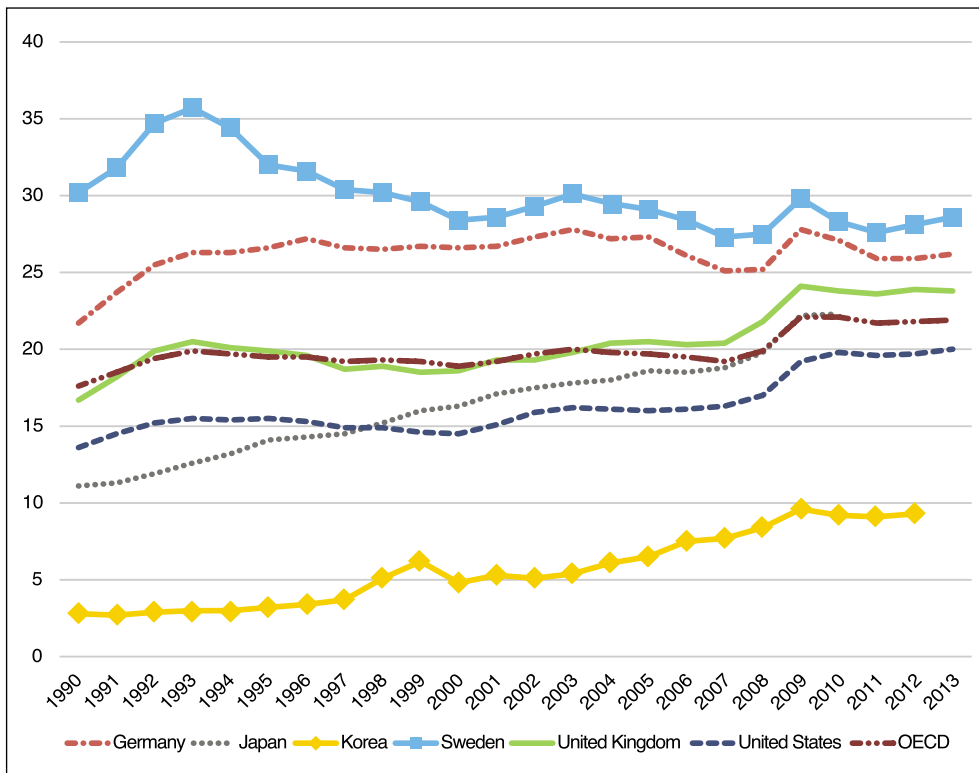
The underdeveloped institutional pluralism in South Korea—with low union membership serving as an example here—is directly related to the dominance of individualized risk management in society. In this context, Ulrich Beck’s argument (1986; published in Korean in 1997 by Saemulgyul) that modernization produces a new kind of “risk society” is relevant. According to Beck, modernization initially takes off as fight against material scarcity and triggers social conflict over the distribution of wealth. Later on, this competition over scarce resources starts overlapping with and is partially replaced by conflicts over new social risks, i.e. risks introduced by the increasing institutional and scientific complexity of advanced societies.

Shin Gyung-ah (2013) discusses Beck’s concept of a risk society in the South Korean context, arguing that society imposes risks on citizens without providing socially institutionalized welfare mechanisms, in contrast to Swedish society, where risk is collectively managed in an “imagined national welfare community” (Hort, 2014b, p. 31). In other words, Koreans experience what has been described as “marketized

individualization” (Shin, 2013, p. 277). In these circumstances, the market acts as the major social institution due to large gaps in the social insurance system in comparison with other OECD societies.

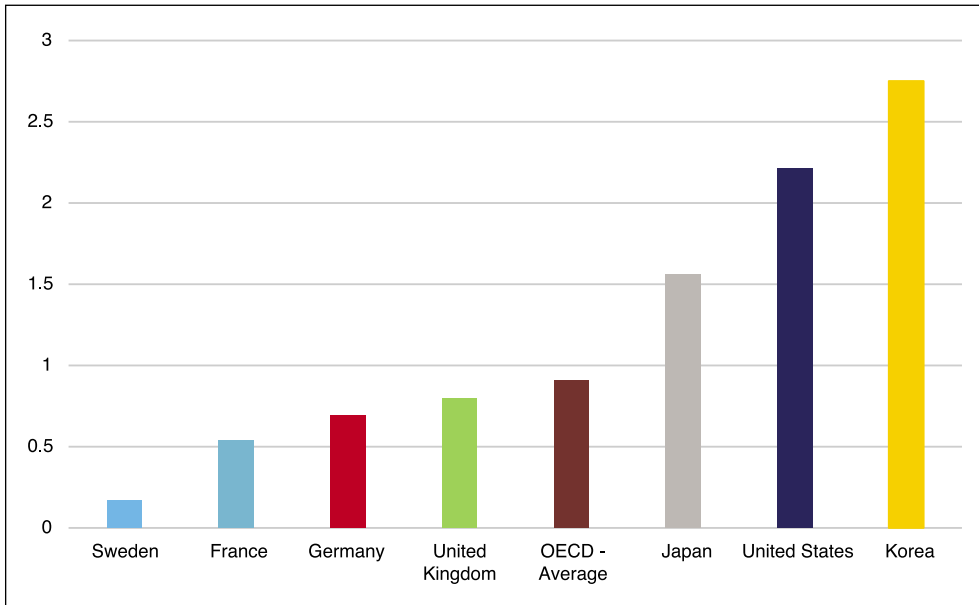
As a result, the community self is not fostered. Instead, competitive individualism is systematically cultivated in South Korean society. This competitive individualism is further reinforced by the fact that citizens have to manage risk individually because they cannot expect help from society. South Korean citizens’ expectation that collectivized risk management is ineffective is reconfirmed whenever governmental disaster management systems fail. Figure 5 shows the share of total social expenditure in gross domestic product (GDP) for OECD countries. South Korea stands out as the country with by far the lowest share of social expenditure in the OECD other than Mexico (a country with a much lower GDP per capita). Figure 6 shows that South Korean citizens must also cover education expenditures privately, which represents a major long-term

Figure 5. Total Social Expenditure from Public Sources (in Percentage of Gross Domestic Product)



Source: OECD iLibrary.

Figure 6. Private Spending on Education for all Levels, % of GDP in 2011 (Source: OECD, Education Database, latest available figures)

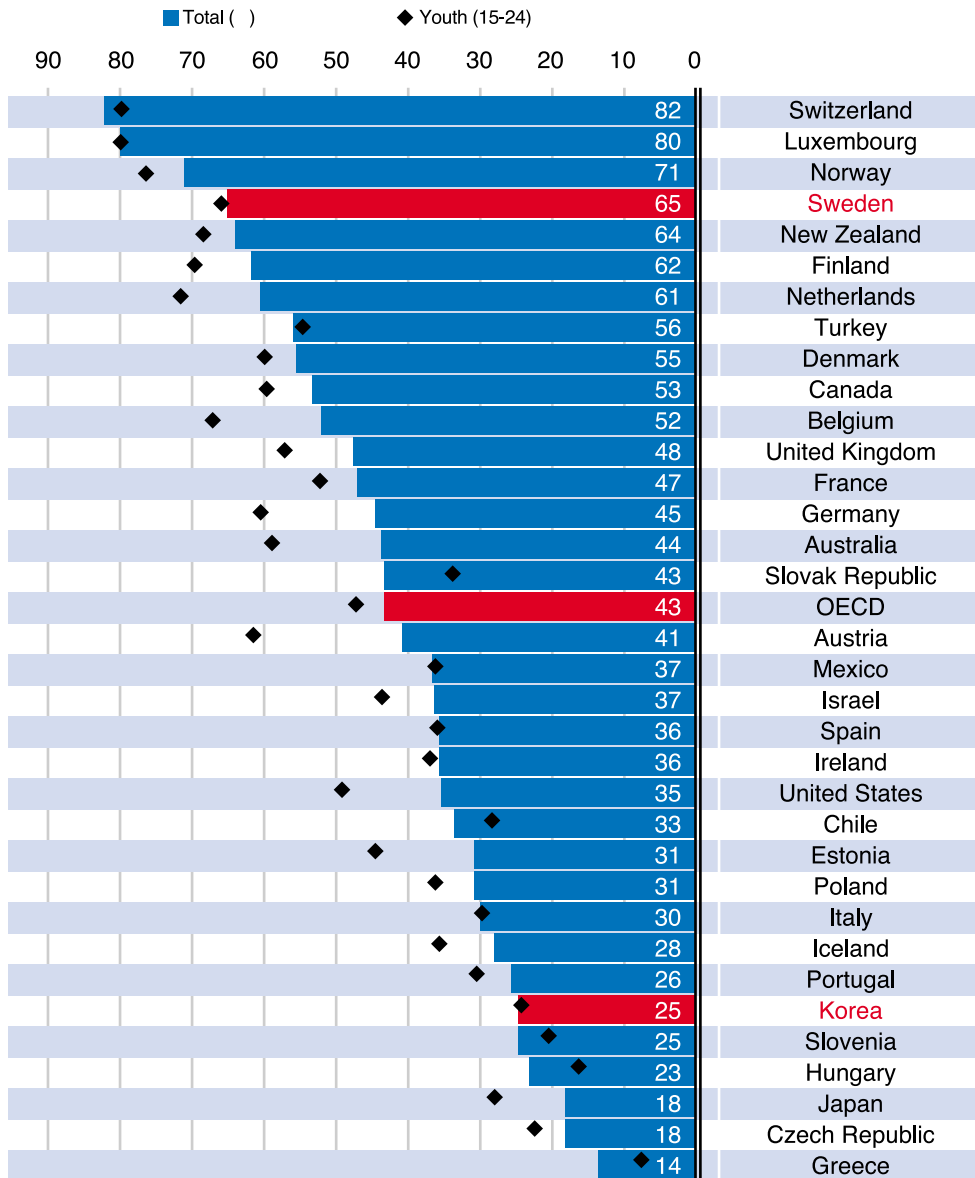


investment on their part, while Swedish citizens mostly cover such costs collectively. In fact, private education spending in South Korea was according to 2011 data the highest in the OECD world.

Thus, different levels of trust in government relate to the relative ability of OECD states to effectively manage risk. Whenever governments fail to provide effective risk management, people may question the utility of paying taxes to the government. The comparative data on trust in government underlines that levels of trust in government are very low in South Korea compared to other OECD countries, as figure 7 shows.

In conclusion, low trust in government and citizens' failure to comply with laws and regulations mutually reinforce each other. According to Max Weber, the concepts of power and authority differ in the sense that power is "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests," whereas authority is "a situation in which a leader's command is taken by the follower and acted on as if the follower valued the action for its own sake" (1978, p. 53, p. 946). In a democratic society, citizens are expected to voluntarily accept state authority rather than be subjected to state power. Yet if citizens do not trust the government, they will not value state-imposed rules. Since the South Korean government enjoys little trust, it is not

Figure 7. Confidence in National Government, 2012 (%)



Source: OECD, 2014.

surprising that citizens frequently fail to comply with laws and regulations, which, among other factors, greatly increases the possibility that accidents will occur.

Thus South Korean citizens do not tend to rely on state institutions when it comes

to risk management. Instead, they rely on their individual relationship with the market, which turns money into the major resource of individualized risk management. A low trust in government causes South Korean citizens to recklessly pursue economic advantage while ignoring laws and regulations. This vicious cycle is the cause and also the effect of the frequent occurrence of major disasters. As long as the vicious cycle remains intact, it will be reinforced and will become even further entrenched as time passes.

Virtuous Cycle in Sweden

The virtuous cycle in Sweden owes the following features: (1) comprehensive modernization; (2) collectivized risk management; and (3) high trust in government. The roots of comprehensive modernization in Sweden date to the late nineteenth century. Although Sweden was at that time a very poor country, similar to South Korea in the 1950s, it was free of a developed feudal system. This early relative egalitarianism allowed political freedom to develop in line with economic modernization and industrialization from the late 1870s onward. Shortly after, the first welfare bills—inspired partially by Bismarckian *Sozialpolitik* in Germany—were passed. A coalition of liberal social reformers and agrarian interests emerged, which was at a later point taken over by the Social Democratic Party (founded in 1889), acting in alliance with the emerging labor unions.

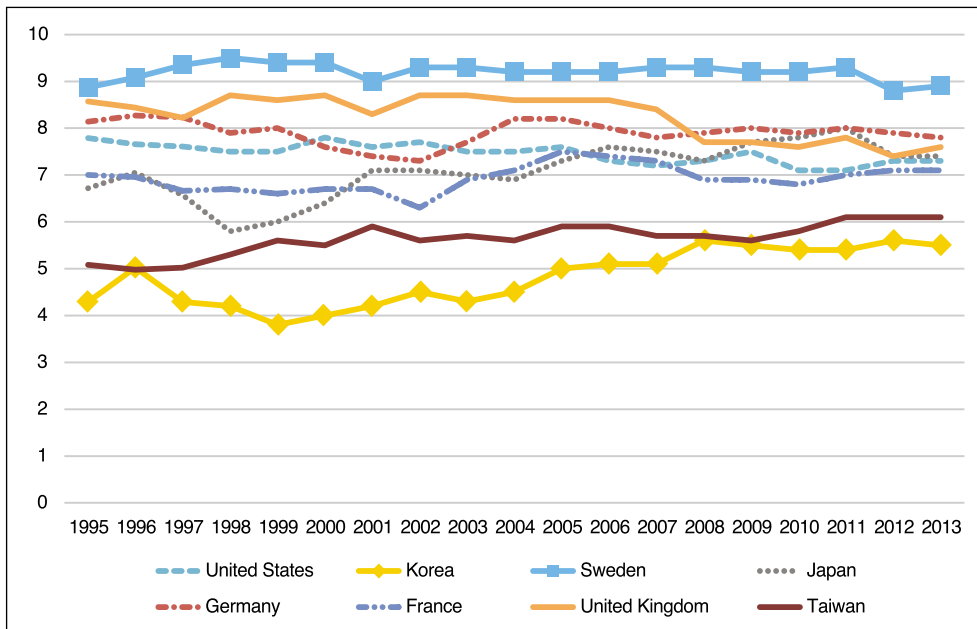
In the 1930s and again after World War II, Sweden expanded its welfare system in areas such as pensions, sickness insurance, child allowances, child support, housing, and labor policies. This expansion helped to reinforce the strength of the alliance of Social Democrats and the trade unions, leading an observer to suggest that “a certain Social Democratic ‘mentality’ has slowly been penetrating Swedish society, politics, and culture: easy to feel, harder to define and clarify” (Hort, 2014a, p. 102). The 1960s were the golden era of welfare policy, during which time it was further expanded in the fields of health care and education, which resulted in “improved social security among the total population; greater equality between the social classes and between single persons and families as well as between retired people and the labor force; and a reduction or elimination of poverty” (Hort, 2014a, p. 155). These developments eventually produced an “imagined community” with high social trust and collectivized risk management institutions.

Thus, risk society in Sweden is buffered by a community self, and Swedish citizens generally accept the necessity of paying high taxes to maintain a generous welfare state, which in turn enjoys high levels of trust. Several explanatory variables for the stability of the Swedish “imagined community” can be found. First, a fairly low

degree of social inequality facilitates high levels of social trust (Rothstein and Uslaner, 2005). Second, there is a high degree of equality of opportunity in the Swedish education system, as the near absence of private spending on education underlines. By contrast, the Korean share of private spending on education is the highest in the OECD world, as shown in figure 6. Third, state institutions in Sweden enjoy very high degrees of trust, as measured by both perceptions of how well corruption is handled as well by how in fact it is managed (see figures 8 and 9). Finally, it has also been argued that high quality universal welfare services are self-reinforcing. Thus, Swedish citizens continue to put their trust in the government due to positive experiences with the services on offer and the perception of fairness in their delivery (Kumlin and Rothstein, 2005).

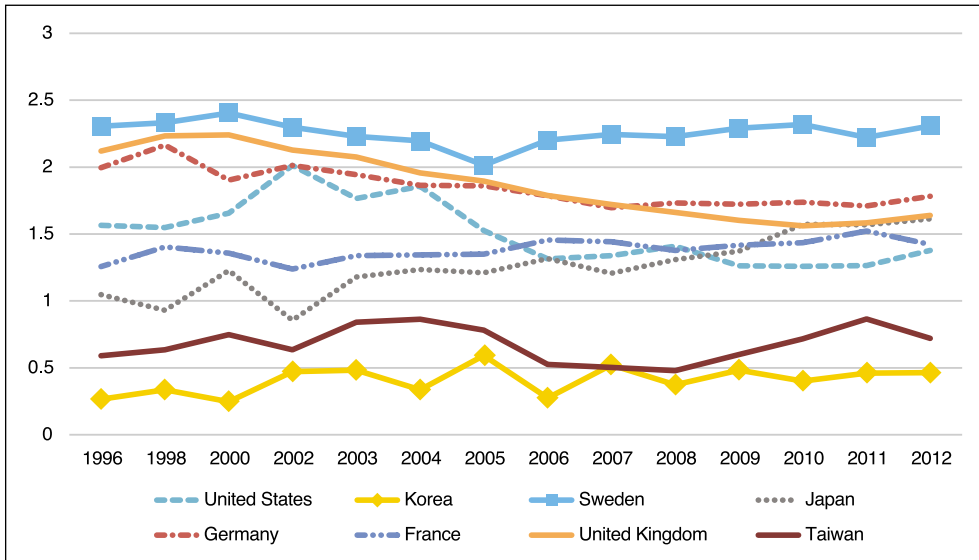
Figures 7, 8, and 9 all add credence to the arguments of Rothstein and Uslaner that “trust, inequality and corruption are all sticky, none of them changes much over time” (2005, p. 65), and that “it seems as if the old saying is true: Once the system gets there, it stays there” (2005, p. 72). The Swedish experience suggests that proactive governments that opt to further develop welfare systems can potentially construct high trust

Figure 8. Corruption Perception Index



Source: Transparency International, 2014.

Note: “The Corruption Perceptions Index (CPI) ranks countries and territories based on how corrupt their public sector is perceived to be. It is a composite index—a combination of polls—drawing on corruption-related data collected by a variety of reputable institutions. The CPI reflects the views of ... experts living and working in the countries and territories evaluated” (Transparency International, 2014).

Figure 9. Control of Corruption

Source: Worldwide Governance Indicators, 2014.

Note: "This indicator measures the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests. It also measures the strength and effectiveness of a country's policy and institutional framework to prevent and combat corruption" (Worldwide Governance Indicators, 2014).

societies, which in turn might motivate citizens to comply with laws and regulations. Yet the opposite logic might also apply: virtuous and vicious cycles are both subject to public policy, and entrenched path dependency can be challenged if the political will to do so exists.

Although a virtuous cycle prevails in Sweden, this does not mean that no accidents have occurred. There have been six major accidents ("major" being defined as an accident with more than 10 casualties) since the 1950s (Swedish Civil Contingencies Agency, 2014). More recently, there have been two accidents, excluding the *MS Estonia* disaster. The first one was a tram accident in 1992 in Göteborg, which killed 13 people and injured 35. Subsequent policy development focused on improving the training and equipment of workers rather than target blaming (*Sveriges Television*, 1992). The second major accident was a discotheque fire in 1998 in Göteborg in which 63 young people died and 190 were injured. Following the accident, an investigative commission made 21 recommendations to different institutions (Statens Haverikommission, 2001). Although not all of the recommendations became law, a lead representative of the Swedish Civil Contingencies Agency, Patrik Perbeck, argues that awareness of safety policies improved, and no similar accidents have occurred since then (*Dagens Nyheter*,

2009).

Finally, it is important to mention current welfare retrenchment in Sweden, although it is beyond the scope of this article to discuss it at length. Here it is sufficient to state that while privatization tends to individualize social risks in Sweden too, Swedish citizens still enjoy generous welfare provisions by comparison with other countries and retrenchment has been modest compared to the rest of the OECD world. The purpose of this section has been to demonstrate how comprehensive modernization and welfare development have interacted in Swedish society and how this allowed for both collective risk management and the building of a high trust society that has been stable over time, which in turn has sustained the three elements of the virtuous cycle.

The next section explains how Swedish policy makers dealt with the worst shipping accident in the country's history.

THE MS *ESTONIA* TRAGEDY AND SUBSEQUENT POLICY DEVELOPMENTS IN SWEDEN

The MS *Estonia* sank on September 28, 1994, claiming 852 lives, including 501 Swedes and 290 Estonians. The ship was first put into service by the Finnish company Rederiaktiebolaget in 1980 to serve routes between Turku (Finland), Mariehamn (Finland), and Stockholm (Sweden). In 1993 it was sold to the Estonian company Estline Maritime Company. All members of the crew were credentialed, and the language of communication on board was Estonian, which was understood by everybody.

The MS *Estonia* departed from Stockholm at 7:15 pm on September 27 with 989 people on board. The weather was initially fair, with a moderate breeze and showers, but it subsequently turned worse, and some passengers reported being seasick just after midnight. At 01:00 am, one of the crew heard a large bang as a wave hit the bow of the ship. He reported this as a normal event, since he could see nothing out of the ordinary. However, the bow visor of the MS *Estonia* was subsequently torn off at 1:15 am, and seawater started to invade. At 1:20 am, the crew issued an alarm, and the first mayday call was registered at 1:22 am. The water entered the ship very quickly, and it completely disappeared from radar at 1:50 am. Government rescue efforts were only initiated an hour after the *Estonia* had sunk, and a rescue helicopter finally arrived at 03:05 am, although four other boats had reached the scene of the accident shortly after the mayday call. Only 138 passengers were ultimately saved. During the following three days, 92 bodies were recovered from the water, while the other passengers remained unaccounted for.

After the catastrophe, it was learned that the MS *Estonia* had been hurriedly con-

structed and that many parts of the ship had been contracted out by the Finnish manufacturer. This included the bow visor that broke off on the night of the accident, resulting in the ship's sinking. At the time of the disaster, other ships also had the type of bow visor the Estonia had. According to the official report, the major technical reason for the disaster was that "no safety margin was built into the bow visors" and that "the ship building industry's experience ... was limited and construction groundwork for bow visors was not well established" (Joint Accident Investigation Commission, 1998, pp. 224-225). Crucially, the report suggested that the accident was not due to issues related to corruption, failure on the part of the crew, or clear-cut regulatory failures. Instead, the extreme weather conditions on the night of the accident created a "black swan" disaster that overpowered all existing safety measures.

Institutional Responses to the MS *Estonia* Accident

After the sinking of the MS *Estonia*, the Swedish government collaborated with all involved parties to set up institutions to examine the causes of the accident. Table 2 summarizes the major activities in the first year after the accident.

Directly after the accident, on September 29, 1994, after a meeting of the prime ministers of Finland, Estonia, and Sweden, a joint accident investigation commission was formed to examine the technical causes of the accident. A second group, "analysgruppen," was formed by the Swedish government to examine the behavior of all state bodies (including parastatal bodies) that were involved in dealing with the accident and its repercussions.

The commission was initially made up of nine maritime and judicial experts from the three countries—Sweden, Estonia, Finland—with only one career politician joining. It had the freedom to work independently from national governments. The *analysgruppen*, which is further discussed in the next section, consisted of five Swedish nationals (three academics, one union leader, and the head of the Swedish Red Cross).

In 1998, an international maritime safety conference was held in Stockholm at which recommendations that arose from the investigation were discussed (Joint Accident Investigation Commission Report, 1998). In 2001, the Swedish Maritime Administration organized another international maritime safety seminar whose goal was to internationalize Swedish policy lessons. This internationalization of policy learning from the MS *Estonia* accident led the International Maritime Organization to issue stricter safety requirements for ferries (*Dagens Nyheter*, 2014).

The responses to the MS *Estonia* accident reflected Swedish collectivized risk management in a number of ways. First, discussions on the MS *Estonia* accident were

Table 2. Swedish Policy Responses to the MS *Estonia* Accident

1994	<p>September 28: the Swedish prime minister meets with the prime ministers of <i>Estonia</i> and Finland; they decide to set up the Joint Accident Investigation Commission.</p> <p>September 28: the Swedish prime minister establishes an emergency group, which has its first meeting that day and starts contacting different agencies to deal with the aftermath of the disaster.</p> <p>September 30: the Swedish Maritime Safety Inspectorate begins inspecting all passenger vessels arriving in Swedish harbors.</p> <p>October 2: national day of mourning.</p> <p>October 3: minute of silence in parliament.</p> <p>October 18: party leaders' meeting.</p> <p>October 19: the Minister of Communication announces that the government has instructed the Swedish Maritime Administration to conduct an analysis regarding how to handle the bodies of the victims of the accident.</p> <p>October 20: the Public Art Agency is instructed to investigate what is required to establish a place of mourning.</p> <p>November 3: a representative is appointed by the government to help the victims to promote their interest.</p> <p>December 1: the government decides to provide financial assistance to organizations of relatives of the victims.</p> <p>December 7: party leaders' meeting.</p> <p>December 12: party leaders' meeting.</p> <p>December 15: the government decides not to salvage the vessel and the disaster site is declared a graveyard.</p> <p>December 22: the government establishes the Maritime Safety Committee, which is charged with developing ways to improve maritime safety.</p>
1995	<p>April 7: the Joint Accident Investigation Commission publishes an interim report concerning technical aspects of the accident.</p> <p>June 1: the parliament approves the decision to sanctify the accident site.</p> <p>September 28: one year after the accident, several memorial events are held throughout the country.</p>

held between leaders of all parliamentary parties of Sweden in 1994, 1996, 1997, and 1999, demonstrating that all parties were collectively taking up the issue of crisis and risk management. Second, October 2 was declared a national day of mourning, and a tax-financed national memorial place containing the names of all the deceased, except for those of 37 victims whose families requested otherwise, was set up in Djurgården, Stockholm, in 1995. The memorial site ensures that there is a space where the tragedy will be remembered, and its construction can also be seen as an act of trust building. Sweden's decision in 1995, together with Finland and Estonia, to sanctify the area where the *Estonia* wreck is located, protecting the graveyard, likewise built trust. Finally, annual memorial ceremonies were held for two decades after the disaster.

Trust Building after the *Estonia* Tragedy

In terms of long-term policies responding to the *Estonia* disaster, the decision of the Swedish government in 2001 to set up a public and state-financed online archive of documents (*Estoniasamlingen*) on the MS *Estonia* tragedy was highly significant. (The resources of this archive have also been utilized in this article.) The website was set up by an agency of the Swedish Ministry of Defense, and since 2011, it has been managed by the Swedish National Archives. It includes all available information on the disaster. Target audiences of the archive are mainly survivors, people related to victims, people who are working on maritime security issues, journalists, students, and the general public. The creation of the online archive underlined that the government was not trying to hide what happened or to make people forget. The provision of value-neutral information has helped to sustain the virtuous cycle of high trust in Swedish society.

The second Swedish government initiative that deserves attention is the *analysgruppen*. The government appointed this group to examine how different societal actors, including state agencies and various voluntary and religious organizations, behaved during and after the crisis. Special emphasis was placed on organizations that relatives of the victims were associated with, which played a major role in helping families cope with their loss.

The group was transparent and the government did not interfere, thus giving it a lot of freedom. Several public hearings and seminars were conducted, and a reference group consisting of survivors and relatives of the deceased further enhanced transparency. The *analysgruppen* helped to restore trust in government activities, which was important because the government and its agencies had initially been criticized for not handling the crisis adequately and for not giving priority to the victims. Although the responsibility to handle a crisis of this scope lay largely with the government, the forming of the *analysgruppen* demonstrated that the government subscribed to the principle of collectivized risk management. All political parties agreed that the *analysgruppen* was needed and that it revived the society, helped citizens to regain trust, and facilitated policy learning (Sveriges Riksdag, 1997). In this context, the group's independence was crucial; other countries should learn from this example that independence and transparency are critical to a successful outcome.

These institutional developments have helped to preserve a virtuous cycle in Sweden. The policy initiatives introduced in the wake of the MS *Estonia* accident show that Sweden has retained its comprehensive modernization strategy. Risk is still collectively managed, and trust in government remains high.

THE MV SEWOL TRAGEDY AND SUBSEQUENT POLICY DEVELOPMENTS IN SOUTH KOREA

The entrenchment of a vicious cycle in Korea has produced numerous disasters. Table 3 shows the three elements of the vicious cycle discussed in section 2, namely (1) economic reductionism, (2) individualized risk management, and (3) low trust in government. The MV *Sewol* tragedy displays all three elements of this cycle.

Table 3. Major South Korean Disasters, 1953-2003

Disaster (Year)	Economic Reductionism	Individualized Risk Management	Low Trust in Government	Notable Aspects
MV <i>Chang-gyung</i> sinking (1953)	O	O	O	<ul style="list-style-type: none"> • 229 out of 236 passengers died • noncompliance with regulations: freight overload • 20-year-old ship (<i>Kyunghyang</i>, 1953; Kang, 2014)
MV <i>Yun-ho</i> sinking (1963)	O	O	O	<ul style="list-style-type: none"> • 140 out of 141 passengers died • noncompliance with regulations: ignored storm alert; passenger and freight overload (<i>DongA-Ilbo</i>, 1963)
MV <i>Nam-yung</i> sinking (1970)	O	O	O	<ul style="list-style-type: none"> • 323 out of 338 passengers died • corruption • noncompliance with regulations: ignored storm alert; passenger and freight overload; illegal reconstruction • malfunctioning disaster prevention system (<i>DongA-Ilbo</i>, 1970; <i>Kyunghyang</i>, 1970; Bae, 2006; Economy Seoul, 2009; Kang, 2014)

Disaster (Year)	Economic Reductionism	Individualized Risk Management	Low Trust in Government	Notable Aspects
Wau apartment building collapse (1970)	O	O	O	<ul style="list-style-type: none"> • 33 deaths, 40 injuries • corruption • noncompliance with regulations: cheap building materials • reckless economic pursuit: illegal construction (Son, 2005)
Dae-yeon-gak hotel fire (1971)		O		<ul style="list-style-type: none"> • 164 deaths, 63 injuries • malfunctioning disaster prevention system: the hotel lacked basic safety features such as sprinklers and a helipad (Team EEJ, 2014)
Dae-wang Corner fire (1974)	O	O	O	<ul style="list-style-type: none"> • 66 deaths, 35 injuries • reckless economic pursuit: owner stopped fleeing customers to ask for payment • malfunctioning disaster prevention system: no training sessions had been supplied (Team EEJ, 2014)
Woo-am commercial complex apartment collapse (1993)	O	O	O	<ul style="list-style-type: none"> • 27 deaths, 48 injuries • reckless economic pursuit: substandard construction • noncompliance with regulations: illegal construction (MBCnews, 1993; T. H. Kim, 2006b; Team EEJ, 2014)
Moogunghwa train accident at Busan Gu-po station (1993)		O	O	<ul style="list-style-type: none"> • 56 deaths, 110 injuries • noncompliance with regulations: nearby construction ignored safety regulations (MBCnews, 1993)
Yeonchun Reserve Army Gunshot Training Center explosion (1993)		O		<ul style="list-style-type: none"> • 19 deaths, 10 injuries • malfunctioning disaster prevention system: no training sessions had been offered (MBCnews, 1993; Team EEJ, 2014)

Disaster (Year)	Economic Reductionism	Individualized Risk Management	Low Trust in Government	Notable Aspects
Asiana Airline 733 plane crash (1993)	O	O	O	<ul style="list-style-type: none"> • 73 out of 106 passengers died • malfunctioning disaster prevention system: possible threat on landing strip • reckless economic pursuit: internal regulations appealed to in order to place blame on pilot (<i>MBCnews</i>, 1993; <i>Team EEJ</i>, 2014)
MV <i>Seohae</i> sinking (1993)	O	O	O	<ul style="list-style-type: none"> • 292 out of 362 passengers died • noncompliance of passengers with regulations • no disaster prevention system in place • deregulation increased the likelihood of accidents (J. G. Kim, 2004; Kang, 2014)
Seongsu Bridge collapse (1994)	O	O		<ul style="list-style-type: none"> • 32 deaths, 17 injuries • reckless economic pursuit: shoddy construction • corruption • malfunctioning disaster prevention system: safety check-ups not performed and no proper state regulatory oversight (<i>MBCnews</i>, 1994; <i>Yonhapnews</i>, 1994, <i>Team EEJ</i>, 2014)
A-hyun-dong City gas explosion (1994)		O		<ul style="list-style-type: none"> • 12 deaths, 101 injuries, 555 affected sam • malfunctioning disaster prevention system: training sessions not supplied (Naver Digital Archive, 1994; <i>Team EEJ</i>, 2014)

Disaster (Year)	Economic Reductionism	Individualized Risk Management	Low Trust in Government	Notable Aspects
Daegu Metro construction site gas explosion (1995)	O	O	O	<ul style="list-style-type: none"> • 102 deaths, 117 injuries • noncompliance with regulations: construction undertaken without permit • malfunctioning disaster prevention system: no safety impact assessment conducted, no information system created to document the buried pipes underground (Park, et al., 2004; T. H. Kim, 2006a; <i>Team EEJ</i>, 2014).
Sampoong department store collapse (1995)	O	O	O	<ul style="list-style-type: none"> • 501 deaths, 937 injuries, 6 missing • corruption • reckless economic pursuit: substandard construction • noncompliance with regulations: illegal construction (<i>MBCnews</i>, 1995; J. S. Kim, 2014; <i>Team EEJ</i>, 2014)
Gyung-gi boarding school fire (1995)		O		<ul style="list-style-type: none"> • 108 deaths • malfunctioning disaster prevention system: no safety personnel in place and doors were locked (<i>Team EEJ</i>, 2014)
Sea Land Youth Training Center fire (1999)	O	O	O	<ul style="list-style-type: none"> • 23 deaths • corruption led to malfunctioning of the disaster prevention system • noncompliance with regulations • no safety personnel in place (<i>Hani</i>, 2013)

Disaster (Year)	Economic Reductionism	Individualized Risk Management	Low Trust in Government	Notable Aspects
Incheon pub fire (1999)	O	O		<ul style="list-style-type: none"> • 57 deaths, 80 injuries • corruption • malfunctioning disaster prevention system: safety training sessions not supplied • reckless economic pursuit: owner stopped fleeing customers to ask for payment (Lee, 2007)
Daegu Metro fire (2003)		O		<ul style="list-style-type: none"> • 192 died, 151 injured • malfunctioning disaster prevention system: safety training sessions not offered • safety concerns ignored during construction process (Daegu Metropolitan City, 2005; Team EEJ, 2014)

Note: Information derived primarily from newspaper archives (*Kyunghyang*, *DongA-Ilbo*, *Hani*, Naver Digital Archive, and *Yonhapnews*), news broadcasts (*MBCnews* and *Team EEJ*), and white papers of the National Archive of Korea and Daegu Metropolitan City.

Table 3 outlines South Korean major accidents and is based on a newspaper survey conducted for the current article. Notably, it includes only incidents that are clearly related to at least one of the three elements of the vicious cycle. Yet even this highly restricted list—which does not take into account those incidents that were not reported on, owing to newspaper censorship before democratization in 1988—confirms that South Korea has a long track record of disasters, supporting the theoretical perspective adopted here. The important point is that the MV *Sewol* tragedy does not differ substantially from earlier tragedies.

This section now proceeds to outline the basic facts regarding the MV *Sewol* tragedy, as they are currently known. The ship was built in 1994 at Hayashikane Shipyard in Japan; Chunghaejin Shipping purchased and imported it to South Korea in October 2012 to undergo reconstruction. On April 15, 2014, at 9:00 pm, the MV *Sewol*, with 476 aboard, including 29 crew members, 325 students, and 15 teachers, departed Incheon after a delay of two and half hours due to thick fog. On April 16, at 8:52 am the MV *Sewol* started tilting close to the island of Jin-Do.

According to Byun (2014), there are three possible reasons a ship may capsize: a

rising in the center of gravity, a rapid shifting of freight, and a rapid turnabout conducted by a crew member, all of which all adversely affect the stability of ships. These factors all seem to have been at play in the case of the MV *Sewol*. The center of gravity of the ship had been raised during its reconstruction. In addition, the amount of cargo carried on the morning of the accident was more than twice the legal limit, and there was not enough ballast water to balance the ship (Board of Audit and Inspection, 2014). After an overangled rapid turnabout at Maeng-Gol channel, which has the second quickest current within the sea areas of South Korea, the ship capsized (Joongang Il-Bo, 2014). The decision to take the turnabout was made by the third mate of the crew, who had less than one year of work experience (Oh, 2014). The ship tilted due to a combination of poor navigation, freight overload, and lack of ballast water.

A student traveling on the *Sewol* called the firefighting headquarters of South Jeolla Province at 8:52 am, and the firefighters passed the emergency call on to Mok-Po Coast Guard at 8:55 am. At that time, a crew member of MV *Sewol* called Jeju Vessel Traffic Service (VTS) to request rescue aid, and Jeju VTS informed Jeju Coast Guard about the accident, but this unit did not respond since it was not in charge of the area where the ship had capsized. Finally the crew of the MV *Sewol* communicated with Jindo VTS, which was in charge of the area, at 9:06 am. The Mok-Po Coast Guard sent a helicopter and a ship to the accident scene, which arrived on the scene at 9:30 am and 9:35 am, respectively, rescuing the captain and crew first at 9:46 am. Yet the coast guard did not call on the passengers to leave the ship. Instead, there were only prerecorded voice announcements being made on the MV *Sewol*, asking the passengers to “not move” until 10:10 am. At 11:18 am, the ship completely sank. The diving rescuers from the Mok-Po Coast Guard and the West Sea Regional Coast Guard were very late, arriving at the accident site at 11:15 am and 11:20 am, respectively. Ultimately, the rescue team was able to save the lives of only 172 of the 476 passengers (Minbyun, 2014). Table 4 shows the category and distribution of saved and deceased passengers.

Table 4.

	Total	Students	Teachers	Ship Crew	Service Crew	Others
Number	476	325	14	15	14	108
Saved	172	75	2	15	5	75
Deceased	304	250	12	0	9	33
Save Rate	36%	23%	14%	100%	36%	70%

Source: Minbyun, 2014: 30.

Modernization Based on Economic Reductionism

Socialized actors are influenced by institutions, and the actors in the *MV Sewol* tragedy were no exception. As discussed in section 2, South Korea's political discourse focuses on economic growth, deregulation, and privatization.

Under the Lee Myung-bak and Park Geun-hye administrations, in particular, deregulatory policies were pursued to "invigorate" the coastwise vessel industry. In 2009, the inspection regime for ships was deregulated, and inspections were only conducted after 9,000 hours of service rather than after 7,000 hours. Prior to deregulation, shipping companies were only allowed to load preapproved cars and freight onto car ferries such as the *MV Sewol*. In 2009, this criterion was loosened, and in addition, freight could now be fixed with ropes on the deck, while the earlier regulations demanded it to be firmly fixed with wedges. Another deregulation concerned how long ships could be operated, which was extended from 20 to 30 years (Minbyun, 2014).

Following the 2009 deregulation, the number of vessels older than 15 years imported by Korean shipping companies increased from 29.4 percent to 63.2 percent. Between 2005 and 2013, the number of vessels older than 20 years increased seven times, to 24 percent of all ships, and that of ships with between 16 to 20 years of service tripled (J. S. Kim, 2014). Before deregulation, ships with more than 15 years of service were subject to special supervisory measures; under the new policy, ships were not subject to such measures until after 20 years of service (Minbyun, 2014).

The Park Geun-hye administration also revised the Seaman Enforcement Ordinance, so that South Korean captains were no longer required to submit documents about the conduct of inspections and first or second mates could now be delegated to lead the ship when captains were absent. In addition, shipping companies were now permitted to hire temporary workers for maintenance and repairs (Roh, 2014). Without deregulation, the Chunghaejin Shipping Company might not have considered importing the 18-year-old *MV Sewol* in the first place, freight would not have moved toward a corner after the ship's sudden turnabout, and an inexperienced third mate would not have been in charge of the ship. In this context, one should also note that South Korean coastwise vessels did not meet international standards even before the 2009 and 2013 deregulations (Cho, 2014).

Chunghaejin Shipping pursued economic profit in a relentless manner. First, the company minimized investment in security, spending only 0.001 percent of total revenue on safety training sessions in 2013. Second, the company did not place a high priority on its crews. Three of the five *MV Sewol* crew members, including the captain, were temporary workers. Their overall salaries were 20 percent to 30 percent lower than those paid by other coastwise shipping companies (Minbyun, 2014). This poor treatment

and the lack of safety training clearly played a role in the way the crew responded during the disaster.

Third, Chunghaejin Shipping failed to comply with regulations in order to further increase profit. Before the disaster, the crew of MV *Sewol* falsified documents indicating the amount of cargo and the number of loaded cars on the ship when reporting to the Korean Shipping Association that is in charge of passenger and freight safety. The reported amount was 657 tons of cargo and 150 cars, but the cargo in fact amounted to 2,142 tons and the number of cars was 185 (Board of Audit and Inspection, 2014). The ballast water tanks for stabilizing the ship were not sufficiently filled: the ship was supposed to have 1565 tons of ballast water, but on the day of the disaster, it only carried 761 tons (Roh, 2014). This fabricated reporting risked the lives of passengers, yet the company falsified documents for 56 out of 118 tours between January and April 2014 (Board of Audit and Inspection, 2014).

Fourth, it was disclosed that the MV *Sewol* crew bribed three commissioners in the Incheon Coast Guard after the ship's reconstruction into allowing Chunghaejin Shipping to skip submitting several crucial documents, which turned out to contribute to the tragedy (Roh, 2014). Finally, in order to get the approval for the reconstruction from the Korean Register of Shipping, Chunghaejin Shipping reported the ship's weight as 100 tons lower than it was and overstated the capacity of the ship to carry cars (Roh, 2014). Ultimately, the incompetency of the Korean Register of Shipping and the fabrications of Chunghaejin Shipping were jointly responsible for the *Sewol* tragedy.

Individualized Risk Management

The behavior of captain and crew of the MV *Sewol* on the day of the accident clearly underlined the absence of a community self. The captain was supposed to lead the crew to deal with the disaster instead of being the first one to escape from the tilting ferry. Other actors also demonstrated an absence of a community self, namely, the executive members of the Ministry of Security and Public Administration who took souvenir photographs (*News1*, 2014), misinformed broadcasters who tried to scoop the story, and members of the coast guard who overstated their rescuing activities (Roh, 2014). They were mostly concerned with their individual selves and failed to live up to the challenge.

More generally, South Korea's disaster prevention system, which is expected to collectively manage crisis situations, malfunctioned in the MV *Sewol* case. According to the Maritime Security Act, the Korea Coast Guard is the core actor of South Korea's disaster prevention system (Roh, 2014). If the rescue efforts of the coast guard

had been successful, the accident would not have turned deadly. However, the rescue process revealed a lack of training and professionalism from beginning to end. The “Manual for Maritime Searching and Rescuing” and a checklist for how to proceed if a ship capsizes explicitly state that rescuers should enter sinking ships to check whether passengers are wearing life jackets and are able to leave the ship immediately. Yet the coast guard did not enter the MV *Sewol* and did not instruct passengers to escape, since the crew, who were equipped with the means of communication, had already left the scene (Roh, 2014). After this display of incompetency, the crew members maliciously tampered with documents, claiming that they ordered the passengers to get out at 9:35 am when in fact they had told the passengers to stay put until 10:10 am (Minbyun, 2014). Moreover, the regional coast guard was not properly trained; the number of training sessions held between 2010 and 2013 was more than half below what was stipulated by the law (Board of Audit and Inspection, 2014).

Jeju VTS and Jindo VTS, which are in charge of observing the relevant sea areas, should have been key actors as well. Jeju VTS initially talked to the crew of the MV *Sewol* and should have used the 30-minute window of time after the accident wisely. Yet Jeju VTS only informed Jeju Coast Guard, which was not in charge of the area where the accident had occurred, and failed to inform the Jindo VTS, which was in charge of the area. Jeju and Jindo VTS lacked communication channels, as they belonged to two different government bodies, namely, the Ministry of Oceans and Fisheries and the coast guard, respectively. Thus, Jindo VTS became aware of the accident only after a significant delay (Minbyun, 2014).

There were other institutional failures as well. For example, the Korean Register of Shipping should have spotted that the freight distribution on the reconstructed MV *Sewol* was dangerous—exceedingly top heavy—and should not have allowed Chunghaejin Shipping to proceed, and the managers of the Korean Shipping Association should have conducted proper safety checks before the ship launched on the day of the disaster (Board of Audit and Inspection, 2014).

These institutional failures indicate a structural proneness to corruption in the safety management system of the shipping industry as a whole. The current system is monopolized by two actors, namely, the Korean Register of Shipping and the Korean Shipping Association. In this context, the only supervisory governmental organization is the Ministry of Oceans and Fisheries; yet liaison between the ministry, on the one hand, and the registry and association, on the other, is obvious. In fact, 10 out of the 12 former chief directors of the Korean Shipping Association and 8 out of the 11 chief directors of the Korean Register of Shipping were appointed after retiring from the Ministry of Oceans and Fisheries. In 2014, 11 out of 14 public organizations related to the Ministry of Oceans and Fisheries also had executives who had previously held a

position in the ministry: such close-knit connection raises questions about the integrity of the disaster prevention system in South Korea (Roh, 2014).

These networks are the legacy of state-led modernization in South Korea, since public officials traditionally had to form a special liaison with related corporations and with respective ministries for the effective mobilization of resources. Today this heritage remains in the form of personnel liaisons between ministries and relevant governmental organizations serving certain functions under the ministries. Once senior officials retire from their ministries, they become lobbyists who seek to link their former workplaces with other governmental organizations. This could perhaps be justified as long as such retired officials were qualified to conduct practical supervisory work. However, if it leads to corruption and the malfunctioning of state institutions, it starts to risk the lives of citizens. Observers have used the term “bureau-fia,” which is a neologism combining the words “bureaucrat” and “mafia,” to describe this relationship between ministries and former ministry officials and have suggested that the failure of the Ministry of Oceans and Fisheries to effectively supervise the Korean Register of Shipping and the Shipping Association before the *Sewol* Disaster illustrates the concept (Roh, 2014).

On the day of the accident, the primary cause of the malfunctioning of the system was the hierarchical order of state institutions. In this order of hierarchy, the Ministry of Safety and Public Administration and the Ministry of Oceans and Fisheries asked the central office of the coast guard to take the lead in the rescue efforts. The coast guard, in turn, handed responsibility off to the West Sea Regional Coast Guard, which in turn asked the Mok-Po Coast Guard to form a central rescue office to head up rescue efforts at the site of the accident.

This hierarchy was established in accordance with the 2013 revised Disaster and Safety Management Organic Law, and its effect was that officials were unable to take action proactively but instead had to wait for orders from the top (Roh, 2014). Moreover, the Ministry of Security and Public Administration lacked the relevant expertise, since personnel from the National Emergency Management Agency, which had been in charge before the revision to the law, had not yet moved to the ministry (Board of Audit and Inspection, 2014).

Due to the institutional complexity of and lack of accountability within the South Korean government, the public has failed to single out any clear-cut target to blame, and most media outlets have focused on the de facto owner of Chunghaejin Shipping, Yoo Byung-Un, members of his family, and Good News Mission, which is a “religion” founded by Yoo (Sisainlive.com, 2014). In fact, most of the South Korean media avoided discussing institutional failure and instead presented the *Sewol* tragedy as due to the unethical behavior of the company owner. Thus, risk management was treated as an individual failure rather than as a systematic problem affecting social institutions.

Low Trust in Government

Low levels of trust in the Korean government weakened state authority. As a result, socialized actors failed to comply with government-issued regulations. Thus, regulations were ineffective in the case of the *Sewol* disaster, and it appears that government actions after the tragedy merely reinforced this low level of trust.

Government officials at the Ministry of Security and Public Administration did not receive accurate information as the tragedy was unfolding, and their press releases reflected that fact. In particular, the ministry kept changing the figures with respect to the number of passengers who had been rescued and kept claiming that the coast guard was entering the ship and that rescuers had been mobilized when this was not the case (Board of Audit and Inspection, 2014). The ministry was misinformed because the information control structure was not arranged properly. In the initial phase of the tragedy, more than 10 relief agencies in different branches of government became involved. However, the Ministry of Security and Public Administration failed to introduce a clear line of command, and therefore it was not in control of crucial information during the rescue.

On May 19, 2014, President Park Geun-hye addressed the nation, announcing several reform schemes in the wake of the *Sewol* disaster. The most dramatic measure was the creation of a new national security agency, concentrating all the safety-related functions of the Korean Coast Guard, the Ministry of Oceans and Fisheries, and the National Emergency Management Agency. This single body is expected to take charge of the central relief actors in the event of future tragedies. Another major reform measure was the introduction of an agency to tackle the poor personnel management of the Ministry of Security and Public Administration (Park, 2014). However, these measures were criticized as mere bureaucratic reshuffling at a time when citizens wanted improvement rather than reorganization (Roh, 2014). Firefighters, whose main agency was supposed to be merged with the new national security agency, argued that the focus should be on providing well-equipped frontline rescuers rather than on making changes within central agencies (*Kyunghyang*, 2014).

In a democracy, government can be improved due to political dynamism deriving from the legislative branch. Parliamentary organizations are especially important in the aftermath of a tragedy, since they provide a venue in which representatives of civil society can respond to the government's proposed agenda. However, this political dynamism does not appear to be in place in South Korean politics. Instead, parliamentary affairs tend to reinforce the tendency of low trust in government.

Initially, the two biggest parties (the government party and the largest opposition party, respectively) quickly consented to an inspection of the administration. The

resulting bill was passed with a vast majority during the plenary session of the National Assembly on May 29, 2014, and was to be implemented from June 2 to August 30 (*Ohmynews*, 2014). However, the inspection turned out to have little impact and the Committee of Bereaved Families reported that after the inspection was concluded, there were still 89 questions that had not been addressed. Jun Myung-sun, vice chair of the Committee of Bereaved Families, said that “these reports were mere show. There is no fruit” (*Kyunghyang*, 2014). The committee subsequently started a hunger strike and a signature campaign to demand a special law to introduce an independent investigatory commission for the accident, a commission that would ideally have the right to directly prosecute guilty parties.

However, the content of the National Assembly draft bill put forward on August 7, 2014, and finally passed on November 7, 2014, did not follow the proposal of the Committee of Bereaved Families. Instead, the two main parties agreed to introduce a special 17-member commission that would be made up of 5 individuals from the ruling party, 5 individuals from the major opposition party, 4 individuals from the Supreme Court and Korean Bar Association, and 3 individuals representing the families of the deceased. While the opposition party floor leader claimed that inclusion of 3 representatives from the families of the victims constituted success, representatives of the families of the deceased were more skeptical. The vice chair of the Committee of Bereaved Families declared that “our opinion is not reflected in this draft” and that therefore “we cannot accept [it]” (*Ohmynews*, 2014). In reaction to this criticism, the major opposition party asked to renegotiate with the ruling party. However, the ruling party refused to enter into such renegotiations.

On August 15, 2014, the floor leader of the ruling party suggested that politics should once again focus on the issue of economic development of South Korea, thereby reinstating the pattern of economic reductionism (*Newstapa*, 2014).

COMPARATIVE DISCUSSION

In South Korea, economic reductionism facilitated deregulatory policies and gave rise to the MV *Sewol* tragedy. In Sweden, economic development has by contrast been historically balanced by a robust welfare system. Integrated and comprehensive modernization in Sweden meant less deregulation and privatization in comparison with South Korea.

These contrasting modes of modernity affected structures and agents alike. Chung-haejin Shipping’s reckless pursuit of economic gain combined with a failure to comply with laws, inadequate investment in its crews, and its bribery of commissioners all

contributed to the disaster. By contrast, no illegal conduct was discovered after the MS *Estonia* disaster, since most of the ship's crew were regular employees and were certified for their positions. The MS *Estonia* tragedy was largely a "black swan" accident, while the MV *Sewol* tragedy was a disaster that could easily have been avoided if the relevant institutions had been functioning properly. In the case of the MS *Estonia*, the crew made an effort to ensure the safety of passengers, even though they were unable to save most of them because the ship sank so quickly. By contrast, the crew members of the *Sewol* were the first to leave the ship.

After the *Estonia* sank, the Swedish prime minister was swiftly informed, and he held a press conference at 11:30 am on the following morning. One day later, the Swedish government established the Joint Accident Investigation Commission. Soon after, the government worked with members of civil society, the Church of Sweden, and other actors to set up a network of institutions to help deal with the crisis. The government appointed a negotiator to serve as a mediator between the bereaved families and the relevant state agencies and held a national day of mourning that enabled Swedish citizens to share the pain of the members of their "imagined community."

The community self prevailed in Sweden; by contrast, the individual self won out in South Korea. Politicians, including the president, did not meet expectations, and citizens remained divided in their evaluation of issues connected with the MV *Sewol* accident. In turn, most of the South Korean media singled out the owner of Chunghaejin Shipping as the major guilty party, reinforcing the tendency to individualized risk management in Korea and avoiding dealing with structural institutional causes that lurked below the surface.

South Korean political debate subsequently focused on the reform of central agencies, although the failure of front-line actors—due to structural proneness to corruption and other shortcomings—was equally significant in triggering the *Sewol* disaster. By contrast, the Swedish government focused on improving the behavior of front-line actors. In the case of the *Estonia* accident, corruption was not a contributing factor, since the parliament's auditing body exercised effective supervision. After the *Estonia* disaster, the Swedish government not only appointed an international investigatory body, the Joint Accident Investigation Commission, but also a national *analysgruppen*. The *analysgruppen* regularly met with people affected by the tragedy to ensure that all parties were represented and were provided with regular opportunities to voice their views. Thus, the Swedish state avoided the sort of fragmented one-by-one examination of institutional flaws that took place in South Korea during the inspections of June and August 2014. Moreover, the bereaved families in South Korea were frequently ignored by the legislators and cut off from public and media discourse.

In the case of the MS *Estonia* inquiry, the Joint Accident Investigation Commission

and the *analysgruppen* collected substantial information and, after delivery of the final report, set up an archive, the *Estonia samlingen*, to allow the general public access to the results of the inquiry. Furthermore, the investigation subsequently contributed to improved international maritime safety policies and national and international policy learning.

CONCLUSION AND POLICY RECOMMENDATIONS

On November 7, 2014, 205 days after the April 16 sinking of the *Sewol*, the National Assembly finally passed three bills related to the accident. These were, in order of importance, a bill calling for the establishment of a 17-member special investigative committee and the installation of a special prosecutor, a bill proposing the reorganization of some government institutions such as the coast guard and the shifting of supervision to a new office of public safety under the prime minister's office, and a bill dealing with the seizure of properties related to economic crimes (Kang, 2014).

While these bills were backed by large bipartisan majorities in the parliament and potentially amount to steps in the right direction, the comparison with the Swedish case strongly suggests that additional steps are necessary to break the vicious cycle of low safety standards and low trust in South Korea. In the light of comparison with the Swedish case, five policy recommendations should be considered: (1) appointing an independent nonpoliticized task force to carry out thorough investigations without predetermined deadlines for a final report; (2) establishing a public *Sewol* archive in line with the *Estoniasamlingen*; (3) expanding resources available to front-line actors responsible for safety and rescue; (4) shifting the national audit body to the legislative branch; and (5) internationalizing policy lessons derived from the MV *Sewol* tragedy.

First, the appointment of an independent investigative task force is essential for policy development, as demonstrated by the Joint Accident Investigation Commission and the *analysgruppen* in the Swedish case. In the case of the Scandinavian and Swedish bodies, members were primarily drafted from among maritime and legal experts and career politicians were with a single exception excluded. Both groups were autonomous and were allowed an unlimited amount of time to conduct inquiries. In South Korea, the special investigative committee is politicized to the extent that the bill calls for the government and main opposition parties to fill 10 of the 17 seats, even though impartial inquiry is most important for future risk management. Moreover, scrutinizing Korean society in general is also necessary in order to advance reforms in a holistic way and to avoid the fragmentation of institutions. There is a danger that the South Korean special investigative committee will be subject to party politics and a

time frame that is too limited.

Second, a public, state-financed and state-managed archive collecting all the information related to the MV *Sewol* tragedy along the lines of *Estoniasamlingen* in Sweden should be set up. While one observer (I. H. Kim, 2014) has proposed to set up a private archive rather than a state-managed one, under the assumption that the contents of a state-managed one might be subject to political interference, such an approach could be short-sighted because the South Korean government requires trust from citizens to ensure their compliance with future safety policies. Moreover, the substantial resources necessary to maintain such an archive would have to be provided by the South Korean state. Installing a public archive could increase trust in government, which could in turn break the vicious cycle of low trust.

Third, the reform of safety policies should focus on front-line actors rather than top-down reorganization. The front-line actors directly deal with disasters and require sufficient resources to do so successfully. Unfortunately, the policy discourses triggered by the focusing event of the MV *Sewol* tragedy mostly concerned central governmental agencies and issues related to frontline actors have hardly been discussed. When fire-fighters raised their voices to ask for better equipment (Kyunghyang, 2014), their voices should have been heard, and also the decision that was made by the government to cut the use of temporary workers in safety-related occupations must be implemented.

Fourth, a shift of institutional supervision of the Board of Audit and Inspection, currently located under the president's office, to the National Assembly should be considered. From a normative point of view, the legislative branch represents a larger variety of actors and a wider range of citizens compared to the president, who is elected in a majoritarian fashion for a single term of five years. Such institutional change, which would require constitutional reform, could potentially deliver a more independent audit body for investigatory action. It could also help to limit the influence of bureau-fia in the future by disassociating the auditing of safety measures from the executive branch.

Finally, the internationalization of policy lessons deriving from the *Sewol* disaster is crucial. At present, the South Korean coastwise vessel industry does not meet the international standard, and earlier rounds of deregulation contributed to the accident (Cho, 2014). The International Maritime Organization imposed an international safety management (ISM) code on oceangoing vessel industries after the famous Titanic tragedy of 1912, and Sweden contributed to the elaboration of this code after the MS *Estonia* tragedy. The South Korean coastwise vessel industry should also become active in international maritime affairs, since crucial lessons can be drawn from the MV *Sewol* tragedy. This could be another step in breaking the vicious cycle that prioritizes the economic growth of the vessel industry over the safety of passengers.

In this article, two cyclically organized path dependencies have been discussed

concerning the histories of modernization in Sweden and South Korea, with an emphasis on a pronounced tragedy each country has experienced. Historical context matters, as the MV *Sewol* tragedy makes clear. The string of man-made disasters must be brought to a halt by breaking the path dependency of the vicious cycle in South Korea. After the *Sewol* disaster, another major accident occurred on October 17, 2014 during a concert in Pan-gyo, when 10 people died after a ventilation grate collapsed (*Yonhapnews*, 2014). This latest major accident demonstrates that the vicious cycle of low safety standards has not been broken, even after the focusing event of the MV *Sewol* tragedy.

Further modernization of South Korea requires a breakthrough in which state agency will remain crucial. The five policies suggested here would allow the South Korean government to regain trust. Higher levels of trust in government are important as they provide one of the necessary preconditions for breaking the vicious cycle in South Korea. Trust-building policies could break the vicious cycle; yet the government needs to earn this trust first. Only a more trustworthy government could comprehensively modernize the institutions and collectivize the risk management in line with successful countries such as Sweden with its “imagined community.” Thus, shifting toward a virtuous cycle of comprehensive modernization should be the aspiration of policy makers in South Korea.

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